



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 425-313-2600. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 425-313-2600 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$2,000 employee only/ \$4,000 employee plus dependents for Preferred and Participating Networks. \$4,000 employee only / \$8,000 employee plus dependents for Out-of-Network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Breast pumps, Cologuard preventive, flu shots and immunizations for all Networks. Preventive care & services for Preferred and Participating Networks.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No. There are no other specific deductibles .	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$5,000 employee only coverage / \$7,350 per individual with employee plus dependent coverage / \$10,000 per family with employee plus dependent coverage for Preferred and Participating Networks. \$10,000 employee only coverage / \$20,000 per individual or family with employee plus dependent coverage for Out-of-Network. Includes Pharmacy.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met
What is not included in the out-of-pocket limit ?	Penalties, ineligible charges, premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.accesshma.com or call 1-800-700-7153 for a list of network providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for

		some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred or Participating Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	_____none_____
	Specialist visit	20% coinsurance	40% coinsurance	_____none_____
	Preventive care/screening/immunization	No charge, <u>deductible</u> does not apply	Not covered	Out-of-Network breast pumps, flu shots and immunizations are covered at no charge, <u>deductible</u> does not apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	_____none_____
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medimpact.com	Generic drugs	20% coinsurance		Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	20% coinsurance		
	Non-preferred brand drugs	20% coinsurance		
	Specialty drugs	Same as retail schedule above		Please contact MedImpact, your specialty pharmacy, for more information on what is covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred or Participating Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	—————none—————
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	—————none—————
	Emergency medical transportation	20% coinsurance	20% coinsurance	—————none—————
	Urgent care	20% coinsurance	20% coinsurance	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Preauthorization is required for partial hospitalization and intensive outpatient.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. Residential treatment is covered.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	—————none—————
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be preauthorized at the time your provider recommends the extended stay.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred or Participating Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required. Limited to a 130-visit calendar year maximum.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization is required for inpatient and is limited to a 30-day calendar year maximum. Outpatient is limited to a 45-visit calendar year maximum. An additional 30 days (inpatient) and 80 visits (outpatient) are allowed for the treatment of stroke, head, or spinal cord injuries. Swim therapy is covered.
	Habilitation services	20% coinsurance	40% coinsurance	Habilitation services, including neurodevelopmental therapy and rehabilitative therapies for the treatment of a mental health diagnosis and substance use disorder, are covered under the Outpatient Rehabilitation Services benefit. Outpatient Rehabilitation Services visit limits do not apply.
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required. Limited to a 120-day calendar year maximum.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required for equipment over \$2,000.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required. Limited to 14 inpatient days. Limited to 240 respite hours every 6 months.
If your child needs dental or eye care	Children's eye exam	Not covered		Please contact vision benefit administrator.
	Children's glasses	Not covered		Please contact vision benefit administrator.
	Children's dental check-up	Not covered		Please contact dental benefit administrator.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

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|-----------------------|--|---|
| • Bariatric surgery | • Infertility treatment (except testing) | • Routine eye care (Adult) |
| • Cosmetic surgery | • Long-term care | • Routine foot care (except if medically necessary) |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Hearing aids | • Private-duty nursing | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| • Acupuncture (20-visit yearly limit) | • Chiropractic care (20-visit yearly limit) |
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Everything Benefits, 800-689-3568, opt.3, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: 1-800-700-7153, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-700-7153.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-700-7153.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-700-7153.]

[Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-700-7153.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$2,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$00
Coinsurance	\$2,120
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,180

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$00
Coinsurance	\$610
What isn't covered	
Limits or exclusions	\$140
The total Joe would pay is	\$2,750

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$2,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$00
Coinsurance	\$160
What isn't covered	
Limits or exclusions	\$00
The total Mia would pay is	\$2,160